ANNUAL LEGISLATIVE PRESENTATION

PARALYZED VETERANS OF AMERICA

RANDY L. PLEVA, SR.
NATIONAL PRESIDENT

BEFORE A JOINT SESSION OF THE HOUSE COMMITTEE ON VETERANS' AFFAIRS AND THE SENATE COMMITTEE ON VETERANS' AFFAIRS

MARCH 8, 2007

Chairman Akaka, Chairman Filner, Members of both Committees, Paralyzed Veterans of America (PVA) appreciates this opportunity to present our legislative priorities for 2007 and the first session of the 110th Congress. PVA would like to thank you, Chairman Filner, for agreeing to rejoin your colleagues in the Senate in the conduct of this joint hearing. This serves as a great opportunity for PVA's leadership and members to participate in the legislative process.

As I sit here today, I cannot help but think that all of these issues that we are presenting for your consideration have an impact on the men and women who are valiantly serving in the Global War on Terrorism. Furthermore, those men and women who have come before them await your consideration of these important issues. It is important for every member of this panel to realize that any lack of action on your part will only hurt these brave warriors. It is our responsibility to ensure that the needs of all veterans, including PVA members with spinal cord injury or dysfunction, are met, whether they served in the past, are currently serving, or will serve in the future.

First, PVA would like to thank both Committees for helping us get the multiple sclerosis centers of excellence codified in Title 38 U.S.C. with the enactment of P.L. 109-461. Due to the bipartisan support of the members of both of these committees, this important segment of the veterans population now can rest easy knowing that the health-care services for Parkinson's disease and MS will be there when they need them.

SEAMLESS TRANSITION FROM DOD TO VA

Perhaps no issue is more important than seamless transition of service members from active duty military status to veteran status. *The Independent Budget* devotes a great deal of attention to addressing the challenges of seamless transition and the areas that need to be improved. However, there are a couple of issues that I would specifically like to address.

First, PVA is concerned that there has been a breakdown in the Memorandum of Understanding between the Department of Defense (DOD) and the Department of Veterans Affairs (VA) for the treatment of service members who incur a spinal cord injury (SCI) while on active duty. The two departments have an agreement that when a service member incurs a spinal cord injury, he or she is supposed to be immediately transferred to a VA medical center with an SCI center. This is necessary because the VA is far better prepared to meet the complex needs of individuals with spinal cord injuries. However, there have been many instances in which these critically injured veterans have been significantly delayed from accessing the VA system because of bureaucratic red tape. It is simply unacceptable to prevent these men and women from receiving this care in a timely manner.

Second, PVA believes that the transfer of a service member's medical records from the DOD to the VA has become a roadblock in the transition process. Slow transfer of this information only leads to further delays in processing a veteran's claim for benefits. Furthermore, it complicates the VA's ability to provide necessary and proper medical care. Injured servicemen and women should not be held hostage by the inability of the DOD and the VA to communicate effectively and efficiently.

The recent revelations about the mishandling of many disabled service members at Walter Reed Army Medical Center prove that the DOD and VA have a long way to go to achieve a seamless transition. It is unconscionable that these brave men and women would be subject to the conditions they faced as they try to transition between two departments that are absolutely responsible for their well-being. Congress cannot allow this to happen again.

FY 2008 VA HEALTH CARE BUDGET

Of utmost importance to PVA and its membership is the VA health care system. Unfortunately, as I testify today, the VA is only now receiving its funding for FY 07, that was just approved a couple of weeks past. Although we certainly appreciate the significant increase in funding provided, particularly for veterans' health care, the VA has already been placed in a critical situation because it was unable to adequately plan for the current fiscal year. It is time for the political wrangling over the VA's budget to stop. The needs of the men and women who have served and continue to serve in harm's way are far more important.

PVA's budget recommendations are part of the joint policy statements contained in this year's *Independent Budget*. They are the combined recommendations of AMVETS, Disabled American Veterans, PVA and Veterans of Foreign Wars. This year, PVA and our fellow Veterans Service Organization (VSOs) are proud to mark the 21st year of this joint effort presenting budget and policy direction to the Congress and the Administration for all benefits and services provided to the veterans of this nation.

For FY 2008, the Administration has requested $34.2 billion for veterans' health care, a $1.9 billion increase over the levels established in H.J. Res. 20, the continuing resolution for FY

2007. Although we recognize this as another step forward, it still falls well short of the recommendations of *The Independent Budget*. For FY 2008, *The Independent Budget* recommends approximately $36.3 billion, an increase of $4.0 billion over the FY 2007 appropriation level and approximately $2.1 billion over the Administration's request.

Although not proposed to have a direct impact on veterans' health-care funding, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription drug copayments from $8 to $15 and an indexed enrollment fee based on veterans' incomes. These proposals will simply add additional financial strain to many veterans, including PVA members and other veterans with catastrophic disabilities. Although the VA does not overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans will leave the system and more than 1 million veterans will choose not to enroll. It is astounding that this Administration would continue to recommend policies that would push veterans away from the best health-care system in America.

I would like to take a moment to explain exactly why PVA particularly objects to the proposal. I would also like to explain why we believe this recommendation, if approved, will have a negative impact on many veterans with catastrophic disabilities whose main health care resource is the VA health-care system.

In 1985, Congress approved legislation that opened the VA health-care system up to all veterans. In 1996, Congress again revised that legislation with a system of rankings establishing priority ratings for enrollment. Within that context, PVA worked hard to ensure that those veterans with catastrophic disabilities, no matter if those disabilities were service-connected or non-service connected, would have a higher enrollment category. If the primary mission of the VA health-care system is to provide for the service disabled, the indigent and those with special needs, catastrophically disabled veterans certainly fit in the latter priority ranking. VA had an obligation to provide care for these veterans. The specialized services, including spinal cord injury care, unique to VA, should be there to serve them.

To protect their enrollment status, veterans with catastrophic disabilities were allowed to enroll in Category Four regardless of their incomes and even though their disabilities were non-service connected. However, unlike other Category Four veterans, if they would otherwise have been in Category Seven or Eight, they would still be required to pay all fees and copayments, just as others in those categories do now for every service they receive from VA.

PVA believes this is unjust. VA recognizes their unique specialized status on the one hand by providing specialized service for them in accordance with its mission to provide for special needs. On the other hand, the system then makes them pay for those services.

Unfortunately, these veterans are not casual users of VA health-care services. Because of the nature of their disabilities they require extensive care and a lifetime of services. Private insurers don't offer the kind of sustaining care for spinal cord injury found at the VA even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of what VA can provide. In most instances, VA is the only and the best resource for a veteran with a spinal cord injury, yet, these veterans, supposedly placed in a priority enrollment category, have to pay fees and copayments for every service they receive as though they had no priority at all.

The Administration's legislative proposals for an indexed annual enrollment fee of $250 to $750 and increases in prescription drug copayments from $8 to $15 would have a severe negative

impact on these veterans. They quite simply create an even higher burden thereby penalizing these veterans for seeking access to the only source of health care they need.

We strongly urge Congress to correct this financial penalty. If a veteran is a Category Four because of a catastrophic disability, treat that veteran like all other Category Fours and exempt him or her from fees and co-payments.

The problems this year, similar to past years, in getting the appropriations bill passed in a timely manner further validates the need to remove veterans' health care from the discretionary budget process and make it mandatory. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient clinic knows how to plan or even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they need them. We look forward to working with the Committees to move legislation through the House and the Senate as soon as possible.

Lastly, we would like the Committees to consider one other possibility. The War on Terror has been funded completely "off budget." Since veterans' health care is a continuing cost of war, perhaps Congress should consider funding the health care for Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans "off budget."

BENEFITS RECOMMENDATIONS

PVA would like to offer a few suggestions for improvements to benefits provided by the VA. PVA members are the number one beneficiary of the Special Adaptive Housing (SAH) grant and the adaptive automobile grant. Unfortunately, periodic increases in these grants have not kept pace with inflation. For both the SAH grant and the adaptive automobile grant, we believe that an automatic annual adjustment indexed to the rising cost of living should be applied. Furthermore, in accordance with the recommendation of *The Independent Budget*, the adaptive automobile grant should be increased to 80 percent of the average cost of a new vehicle to meet the original intent of Congress.

We would also like to recommend an additional change to the SAH grant. P.L. 109-233, the "Veterans' Housing Opportunity and Benefits Improvement Act of 2006" allowed disabled veterans who are residing with a family member to receive a grant up to $14,000 to modify the family member's home for accessibility needs. PVA believes that this option should be extended to severely disabled service members who are still on active duty awaiting discharge from the military. A similar provision already exists for the full SAH grant.

PVA would also like to recommend a change in the compensation provisions outlined in Title 38, Section 5111. Under current law, the effective date for a veteran's finding of service connection is the day after his or her date of military discharge. However, the effective date for his or her VA compensation payments is the first day of the month following the month when that service connection was granted. Because the veteran's compensation payment for a given month is not made until the end of the month, he or she could lose up to an entire month's worth of pay under this current provision. We believe the law should be changed to make the veteran's effective date of service connection and effective date for compensation payment the same.

VA WORKFORCE

PVA is concerned that the VA continues to experience a serious shortage of qualified, board-certified spinal cord injury (SCI) physicians, making it difficult to fill the role of chief of a Spinal Cord Injury or Dysfunction (SCI/D) service. Several major SCI/D programs are under "acting" management with resultant delays in policy development and a loss of continuity of care. In some VA hospitals the recruitment for a new chief of service has been inordinately prolonged with acting chiefs assigned for indefinite time periods.

We are even more concerned about the continuing shortage of nurses, particularly in spinal cord injury units. PVA believes that the basic salary for nurses who provide bedside care to SCI veterans is too low to be competitive with community hospitals. This leads to high attrition rates as these nurses seek better pay in the community. Recruitment and retention bonuses have been effective at several SCI centers, resulting in an improvement in the quality of care for veterans as well as the overall morale of the nursing staff. Unfortunately, these are localized efforts by the individual VA medical facilities. We believe that the Veterans Health Administration (VHA) should authorize substantial recruitment incentives and bonuses. We call on Congress to conduct more oversight of the VHA in meeting its nurse staffing requirements for SCI units as outlined in VHA Directive 2005-001. Currently nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care. Furthermore, not all SCI centers are in full compliance with the regulation for the staffing ratio of professional nurses to other nursing personnel. With proper congressional oversight, these mistakes can and must be corrected.

PVA is also concerned that VA has not requested adequate staffing to deal with the ever-growing claims backlog in the Veterans Benefits Administration (VBA). It is a known fact that the VA's adjudication workforce is rapidly approaching retirement age, and unless new employees are plugged into the pipeline, the VBA may crumble under the weight of the claims workload. Congress must take immediate action to force the VA to hire critically needed adjudications staff, to include providing a substantial increase in funding.

The VHA and the VBA face an impending crisis with its workforce. If we do not begin planning and preparing for the exodus of these employees, services for veterans will suffer.

CONSTRUCTION ISSUES

PVA believes that the time to address the large number of construction issues facing VA is now. Unfortunately, throughout the entire Capital Asset Realignment for Enhanced Services (CARES) process, construction needs were severely neglected. The Administration cannot continue to put off new construction or critically needed facility upgrades and maintenance.

PVA appreciates both Committees authorizing new SCI centers in Syracuse, New York and Milwaukee, Wisconsin, as well as facility improvements at the SCI center in Tampa, Florida. However, as we all know, this is only the first step. It is incumbent upon Congress to appropriate the actual funding needed to see these projects through to completion.

Aggressive oversight is also necessary to ensure that the renovation of the medical facility in Puerto Rico appropriately meets the needs of veterans in that area. Included in this project are improvements to the SCI center. PVA hopes that as this project progresses necessary funds

will be provided to build the most state-of-the-art facility possible. Furthermore, we urge Congress to follow up on the report required by P.L. 109-461, which asks the VA to study options for additional health care access for veterans living in Puerto Rico, and submit this report to Congress in six months.

Finally, we have serious concerns about any proposed joint projects that mirror the planned project in Charleston, South Carolina. This project is meant to be a collaborative effort between the VA and the Medical University of South Carolina. PVA adamantly opposed this provision of P.L. 109-461. The legislation approves funding for advanced planning and design. We generally oppose any agreement that would essentially integrate VA medical center patients into the patient population of other facilities with which it has established agreements. We remain concerned that the joint-use facility planned in Charleston does not address this concern. We also believe that VA leadership should have direct line authority and accountability for veterans' health care. Furthermore, there needs to be a clear understanding of how an integrated system will deal with systemwide directives, handbooks, manuals, and other documents specific to the VA facility. Similar to this issue is direct management of the system. In any collaborative relationship, the VA must maintain current procedures and policies for the provision of appropriate pharmaceuticals, supplies and prosthetics. None of these issues were properly addressed during the consideration of this measure.

SCI/D LONG TERM CARE ISSUES

PVA needs the Committees' help in closing the current and future VA nursing home care bed gap that exists for veterans with SCI/D. Today, waiting lists exist for the four designated SCI/D long-term care facilities and VA's CARES SCI/D long-term care data project significant gaps in capacity for 2012 and 2022.

VA's CARES data project a VA SCI/D nursing home gap of 705 beds in 2012 and an even larger gap of 1,358 beds in 2022. This pending crisis is made even clearer when we realize that VA currently operates only four designated long-term care facilities for veterans with SCI/D and none of these facilities are located west of the Mississippi River. This lack of services in the western portion of the country is especially troublesome for a nationally distributed population. These four existing facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility in Chicago, Illinois (28 staffed beds); and Castle Point, New Jersey (16 staffed beds).

Currently, the combined VA nursing home care capacity for veterans with SCI/D in these four facilities totals only 121 staffed beds. Therefore, the looming crisis of a 705 bed gap in 2012, just five years away, is of serious concern to PVA. The projected gap of 1,358 beds in 2022 further heightens our concern.

PVA was hopeful that VA's CARES initiative would bring some needed relief to this dire situation in the short run. CARES proposed adding 100 SCI/D long term care beds at four new locations. These locations were in Tampa, Florida (30 SCI/D LTC beds); Cleveland, Ohio (20 SCI/D LTC beds); Memphis, Tennessee (20 SCI/D LTC beds); and Long Beach, California (30 SCI/D LTC beds). However, the CARES proposals have proven to be slow movers. To date, only the Tampa and Cleveland sites are moving forward, and remain several years from completion. The sites at Memphis and Long Beach haven't even entered the planning phase.

Because of the looming VA SCI/D LTC bed gap, PVA would like to propose some solutions to provide relief to the growing capacity problem. First, the VA should take immediate steps to address the looming capacity gap for veterans with SCI/D. Secondly, VA should determine a specific amount of bed space to be designated for veterans with SCI/D during VA's grant allocation process for the construction of new State Veterans' Homes. This requirement should also provide for accessible facility design and require SCI/D staff training. Finally, VA and Congress must fast-track the CARES SCI/LTC recommendations. The need is well documented and was included as recommendations in the CARES Commission's report that was released in 2004.

VA must move forward in the development of institutional care programming for young OIF and OEF veterans whose combat injuries are so severe that they are forced to depend on VA nursing home care. VA's current nursing home capacity is designed to serve elderly veterans, not young ones. VA must make every effort to create an environment for these veterans that recognizes that they have different needs. VA leadership and VA planners must work to bring a new type of long-term care program forward to meet these needs.

Young veterans must be surrounded by forward-thinking administrators and staff that can adapt to youthful needs and interests. The entire environment must be changed for these individuals not just modified. For example: facility design, therapy programs, individual living space, meals, recreation programs, and administrative policy must be changed to adapt to a younger more vibrant resident.

VA must also do thoughtful planning in developing progressive new non-institutional long-term care programs that will enable as many young veterans with severe disabilities to return to their local communities as possible. VA operates a range of non-institutional long-term care programs, but these programs were designed to serve an elderly population. New thinking needs to be brought to bear on how to design and provide services that enable these young veterans to live independent and productive lives in their local communities.

PVA continues to advocate that Congress require VA to maintain the VA nursing home average daily census capacity mandate as outlined in Public Law 106-117. The aging of America's veteran population requires this minimum level of capacity. VA has well documented the aging of the veteran population. VA has also emphasized that the number pf America's oldest veterans, those 85 and older, will dramatically increase from 540,000 in 2000 to more than 1.3 million by 2012. VA says, "This oldest segment of the veteran population has had, and will continue to have, significant ramifications on the demand for health-care services, particularly in the areas of long-term care."

Additionally, Mr. Chairmen, PVA would like to take this opportunity to congratulate VA's Geriatric and Extended Care Program staff for finding new methods of providing non-institutional long-term care services to America's veterans. These innovative programs enable thousands of aging veterans to remain in their own homes and in many cases avoid or delay admission to nursing home care units. PVA has been a strong advocate for home and community-based (non-institutional) long-term care programs.

Finally, Mr. Chairmen, PVA would also like to congratulate Congress, and particularly the Senate and House Veterans' Affairs Committees, on recognizing the growing need for a VA long-term care strategic plan. Passage of Public Law 109-461 required VA to develop a strategic long-term care plan that will meet the current and future needs of America's aging

veterans. The need for a VA strategic long-term care plan has been recognized by Congress, the CARES Commission, and by the coauthors of *The Independent Budget.*

CONTRACT CARE COORDINATION

I would like to address the continued efforts of VA to contract out health care services—efforts that could have a substantial negative impact on the VA health care system. P.L. 109-114, the "Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act of 2006" authorized VA to conduct a contract care coordination pilot program. This pilot program developed into Project HERO. Since its inception, PVA, and many other veterans service organizations have expressed serious concerns with this project.

We believe that VA's approach to this program will lead to contracted health care services provided by non-VA providers on a broad basis. This only serves to dilute the quality and quantity of VA services for new as well as existing veteran patients. Ultimately, contract care is not more cost effective or cost efficient than care provided by the VA, and we certainly do not believe that the VA will find the same level of high-quality care in the private sector.

Initially, the veterans service organizations were left out of the development of the Project HERO. However, because we voiced serious concerns with the program to VA and to Congress, the veterans service organizations have been given at least some role in the development of the program. Specifically, we have recently been advised that the revised Request for Proposal (RFP), issued on January 12, 2007, would have a more limited scope, with its primary objective to reduce overall VA contract care costs while improving service to veterans eligible for, and now receiving, VA contract health-care services. While we appreciate this reduction in scope, and certainly the professionalism and courtesies of the VA staff in attempting to assuage our concerns, we remain concerned that this pilot project may result in an overall increase in contract care costs and further erode the already limited resources available to provide clinical care within the VA.

Also, we are concerned that the Appropriations Committees' original direction to the VA, to recognize and be sensitive to the importance of academic affiliations, may not have fully been reflected in the development of the VA's solicitation. The loss of these affiliations would be a serious blow to the quality of care available to veterans.

We are proud of the accomplishments of the VA in health care and do not want what has become a model for the nation to deteriorate by expansion of contracted-care dollars into a market that reduces VA control over the quality of care provided. Ultimately, we fear that costs of implementing Project HERO will exceed the benefit to veterans receiving care from the VA. We will continue to monitor the development of this pilot program, and we hope Congress will be vigilant in doing the same.

PVA appreciates the opportunity to present our legislative priorities and concerns for the first session of the 110th Congress. We look forward to working with the committees to ensure that adequate resources are provided to the VA health- care system so that eligible veterans can receive the care that they have earned and deserve. We also hope that the committees will take the opportunity to make meaningful improvements to the benefits that veterans rely on.

Mr. Chairmen, I would like to again thank you for the opportunity to testify. I would be happy to answer any questions you have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2006

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $244,611 (estimated).

Fiscal Year 2005

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $193,019.

Paralyzed Veterans of America Outdoor Recreation Heritage Fund – Department of Defense – $1,000,000.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $246,541.

RANDY PLEVA
PVA NATIONAL PRESIDENT

Randy L. Pleva, Sr., was re-elected to a third term, as national president of the Paralyzed Veterans of America (PVA) during PVA's 60th Annual Convention in San Diego, California on September 1, 2006.

Previously, he served as national senior vice president and three years as national vice president. Pleva joined the Kentucky/Indiana Chapter in 1989. He later helped form the West Virginia subchapter. After chapter status was granted to West Virginia PVA in 1992, Pleva was elected as its first president and national director. Pleva has held these positions for eight years. For the past 11 years, he has served on numerous state and federal committees, either as a member of the board of directors or chairman. In 1998, West Virginia Governor, Cecil H. Underwood, appointed Pleva as Americans with Disabilities Act coordinator.

Pleva joined the US Marine Corps in 1971 and served with the Task Force Delta Unit in Southeast Asia. He was discharged in 1974, became employed as a coal miner and United Mine Workers mediator. In 1982, he sustained a spinal cord injury in a coal mining accident.

Pleva currently resides in Tad, West Virginia.